BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **RUBEN AGUILERA, M.D.** Holder of License No. **10747** For the Practice of Allopathic Medicine In the State of Arizona.	Board Case No. MD-09-0805A and MD-09-0957 **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Decree of Censure with Probation)

The Arizona Medical Board ("Board") considered this matter at its public meeting on June 9, 2010. Ruben Aguilera, M.D., ("Respondent") appeared with legal counsel, Kraig J. Marton, before the Board for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue Findings of Fact, Conclusions of Law and Order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 10747 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-09-0805A after receiving a complaint regarding Dr. Aguilera's care and treatment of patients DMP and DHP alleging inappropriate prescribing of narcotics.

4. On September 14, 2007, DHP became a patient of Dr. Aguilera. He was receiving prescriptions for pain medication at that time for chest pain believed to be of noncardiac origin. He saw a pain management specialist previously who recommended discontinuing narcotic therapy. Dr. Aguilera increased DHP's narcotic

medication. During his treatment with Dr. Aguilera, DHP saw another pain management specialist who recommended inpatient detoxification. Despite this recommendation, Dr. Aguilera continued to prescribed oxycodone and methadone to DHP, who subsequently lost his job due to being sedated while at work.

5. On September 17, 2007, DMP became a patient of Dr. Aguilera. She was seen in the emergency room prior to her scheduled follow up visit with Dr. Aguilera and was treated with morphine. She was discharged on oxycodone, which was continued by Dr. Aguilera.

6. In October 2007, DMP was prescribed Dilaudid that was discontinued a week later and replaced with oxycodone. Dr. Aguilera refilled the prescription for oxycodone 30mg #120 the following month, and added oxycodone 15mg #150. DMP reported having multiple syncopal episodes and was evaluated by a cardiologist who diagnosed her with supraventricular tachycardia (SVT); she also received prescriptions for Xanax.

7. In December 2007, DMP reported losing her medication one week after receiving a prescription for oxycodone. Dr. Aguilera provided her with prescriptions for oxycodone 15mg and 30mg in unspecified amounts. In February 2008, DMP received prescriptions for oxycodone 15mg #240 and 30 mg #120, and reported more syncopal episodes, including one while driving. In June 2008, DMP admitted to using more medication than prescribed; nevertheless, Dr. Aguilera continues to prescribe DMP large quantities of oxycodone.

8. The Medical Consultant (MC) identified multiple deviations from the standard of care and found that there was documented actual harm as well as much greater

potential harm. The MC stated that treatment continued despite the lack of defining a clear source of chronic pain, and despite the opinion of a pain management physician that DHP's narcotic therapy be discontinued. The MC noted that the process of detox was recognized as necessary, but postponed for reasons that were not justified. The MC stated that the pattern of excessive medication prescribing, as evidence by the use of multiple muscle relaxants in the case of DHP, is of great concern.

9. The Board initiated case number MD-09-0957A after receiving a complaint regarding Dr. Aguilera's care and treatment of a 31 year-old male patient ("MF") alleging inappropriate prescribing.

10. On November 4, 2008, MF presented to Dr. Aguilera's office and was seen by the family nurse practitioner (FNP). It was noted that MF's reported pain was incompatible with his ease of movement. MF was given a full one-month supply of the medication (oxycontin 80mg BID and oxycodone 30 mg QID) he claimed to be taking. Flexeril was also prescribed in an attempt to reduce MF's need for narcotics. Two days later, MF's records were received from the previous primary care provider and made no mention of pain and did not indicate that narcotics were supplied. From December 2008 through March 2009, MF's narcotics were refilled, Soma was prescribed in place of Flexeril, and MF was advised to retrieve his x-ray report. MF brought in a CT report of the brain that was normal, and a cervical spine CT report that showed degenerative disc disease.

11. The FNP discussed with MF the option of seeing a chiropractor and increased the Soma from twice to three times per day. Cervical, thoracic, and lumbar spine films showed normal lumbar vertebral height and alignment, with mild lower thoracic through

T12-L1 degenerative endplate changes. The C6-7 disc space was narrowed, with mild left foraminal narrowing due to uncovertebral spurring. MF was asked to schedule an appointment for a MRI, but continued to cancel or not show up for the scheduled appointments. MF was first seen by Dr. Aguilera on March 27, 2009. His hypertension medication was increased and there was no change in the pain therapy. From April through July of 2009, MF continued to cancel his MRI appointments. Although Dr. Aguilera's nurse practitioner noted that MF was to have no narcotics until the MRI was done, Dr. Aguilera decreased the oxycontin dose once and then continued to refill the medications without further changes, documenting that MF was resistant to further changes. MF did not obtain the MRI.

12. The Medical Consultant (MC) found Dr. Aguilera's practice to be susceptible to being manipulated by a deceptive patient. The MC opined that Dr. Aguilera and his staff need to understand that they cannot accept a patient-defined urgency for starting therapy in the face of red flags and a lack of supporting documentation.

13. At his Formal Interview, Respondent admitted that, by prescribing controlled substances in escalating dosages to DHP and DMP, they ended up on higher doses of narcotics than they would have been if Respondent had curtailed the dosages earlier in the process.

14. Respondent also testified that he had changed his practice since these complaints were filed. He stated that he was no longer accepting chronic pain patients and was doing drug screens quite frequently. In addition, he claimed that he no longer treats patients until he has had an opportunity to review their past medical records.

15, Respondent also noted that half of his practice is in the hospital where he has had no prescribing issues at all. He stated that if he were restricted from prescribing

controlled substances in any setting, he would be unable to continue his practice as a hospitalist.

16. The standard of care in the prescription of chronic narcotic therapy for nonmalignant conditions requires a physician to select the appropriate immediate and sustained release medications, as well as proper clinical judgment related to the merits of the escalating doses of medication.

17. Respondent deviated from the standard of care by failing to select the appropriate immediate and sustained release medications and by escalating dosages of pain medication for DMP and DHP.

18. DMP experienced syncopal episodes, presumably primarily of cardiac origin. Despite her admitting to at least one syncopal episode while operating a motor vehicle, no reduction in narcotic therapy was made. DHP lost his job due to oversedation while at work.

19. Both patients could have potentially experienced greater harm, including life-threatening complications. At the dosages described, respiratory depression is a concern. Oversedation during activities such as operating a motor vehicle could have resulted in harm to the patients, and to others.

20. The standard of care requires a physician to have exam findings, radiographic findings and/or previous medical records to support treatment for chronic pain patients.

21. Respondent deviated from the standard of care by failing to have exam findings, radiographic findings or previous medical records to support treatment for chronic pain.

22. The standard of care requires a physician to assess for diversion through urine or blood drug screens, especially in high risk patients.

23. Respondent deviated from the standard of care by failing to recognize the high-

risk nature of MF and failed to order a drug screen to verify use versus diversion.

24. MF apparently sold his prescriptions for oxycontin and oxycodone, increasing the availability of illegally sold narcotics.

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S § 32-1401(27)(q) ("[a]ny conduct that is or might be harmful or dangerous to the health of the patient or the public.")

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED:

1. Respondent is issued a **Decree of Censure**.

2. Respondent is placed on **probation** for **10 years** with the following terms and conditions:

   a. Respondent is restricted in that he shall prescribe, administer, or dispense Controlled Substances only in his capacity as a hospitalist in the hospital and inpatient hospice settings.

   b. Respondent shall be subject to periodic chart reviews to be conducted by a Board approved monitoring company. Based

upon the chart review, the Board retains jurisdiction to take additional disciplinary or remedial action.

c. Within 30 days of the date of this order, Respondent shall enter into a contract with a Board approved monitoring company to provide all monitoring services under this Order. Respondent shall be responsible for the payment of all monitoring costs.

d. Respondent shall obey all state, federal and local laws, all rules governing the practice of medicine in Arizona, and remain in full compliance with any court ordered criminal probation, payments and other orders.

e. In the event Respondent should leave Arizona to reside or practice outside the State or for any reason should Respondent stop practicing medicine in Arizona, Respondent shall notify the Executive Director in writing within ten days of departure and return or the dates of non-practice within Arizona. Non-practice is defined as any period of time exceeding thirty days during which Respondent is not engaging in the practice of medicine. Periods of temporary or permanent residence or practice outside Arizona or of non-practice within Arizona, will not apply to the reduction of the probationary period.

3. The Board retains jurisdiction and may initiate new action based upon any violation of this Order.

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RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 11th day of August

THE ARIZONA MEDICAL BOARD

By Amanda Bien
for Lisa S. Wynn
Executive Director

ORIGINAL of the foregoing filed this 11th day of August 2010 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing
mailed by U.S. Mail this
11th day of August, 2010 to:

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